

NOV 12 1996

IN THE
Supreme Court of the United States CLERK

OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*,
v. *Petitioners*,

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Second Circuit

STATE OF WASHINGTON,
v. *Petitioner*,

HAROLD GLUCKSBERG, *et al.*,

Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

**BRIEF OF THE AMERICAN GERIATRICS SOCIETY
AS AMICUS CURIAE URGING REVERSAL
OF THE JUDGMENTS BELOW**

Of Counsel:

JOSEPH E. SCHMITZ
MAKAN DELRAHIM
PATTON & BOGGS, L.L.P.
2550 M Street, N.W.
Washington, D.C. 20037
(202) 457-6000

JOHN H. PICKERING *
ALI M. STOEPPELWERTH
WILMER, CUTLER & PICKERING
2445 M Street, N.W.
Washington, D.C. 20037
(202) 663-6200
* Counsel of Record
Counsel for Amicus Curiae

48 PV

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF AMICUS CURIAE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. THE COURTS WERE MISLED BY MISPERCEPTIONS ABOUT END-OF-LIFE EXPERIENCES	4
A. The Patient-Plaintiffs Are Not Representative of Dying Persons Generally	4
B. Dying Is Mischaracterized as Unavoidably Dreadful	6
C. The Lower Courts Misperceived Current Shortcomings in Care at the End of Life as Persistent and Unchanging	9
II. THE COURTS BELOW MISTAKENLY CONCLUDED THAT PHYSICIAN ASSISTED SUICIDE IS NO DIFFERENT FROM FOREGOING LIFE-SUSTAINING TREATMENT....	11
A. Descriptive Aspects Differentiate the Two Situations	12
B. Rights Against Interference Are Stronger Claims Than Those for Assistance	13
C. The Restriction of Physician Assisted Suicide to a Narrow Class of Persons Highlights Its Differences From Foregoing Life-Sustaining Treatment	14
D. The History of Familiarity With Foregoing Life-Sustaining Treatment Contrasts Sharply With the Lack of Experience With Physician Assisted Suicide	14

TABLE OF CONTENTS—Continued

	Page
III. THE CONSTRAINTS PROPOSED FOR THE PRACTICE OF PHYSICIAN ASSISTED SUICIDE PRESENT INTRACTABLE PROBLEMS	15
A. Terminal Illness	16
1. Subjective Determination	18
2. Statistical Determination	18
3. Disease Threshold	20
B. Competence	21
C. Undue Influence - Coercion	23
1. The Context of Care	23
2. Financial Considerations	24
D. Suffering	25
E. Physician Involvement	25
F. The Scope of Assistance	26
IV. THE COURT SHOULD VACATE THE ORDERS OF THE LOWER COURTS	27
CONCLUSION	29
APPENDIX	1a

TABLE OF AUTHORITIES

CASES	Page
<i>Compassion in Dying v. State of Washington</i> , 79 F.3d 790 (9th Cir. 1996)	3, 6, 10, 16
<i>Cruzan v. Director, Missouri Dept. of Health</i> , 497 U.S. 261 (1990)	4, 7, 9, 13, 14
<i>Garcia v. San Antonio Metropolitan Transit Authority</i> , 469 U.S. 528 (1985)	28-29
<i>In re Quinlan</i> , 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976)	7, 9, 13, 14
<i>Mugler v. Kansas</i> , 123 U.S. 623 (1887)	28
<i>New York v. United States</i> , 505 U.S. 144 (1992)	28
<i>Quill v. Vacco</i> , 80 F.3d 716 (2d Cir. 1996)	3, 8, 13, 16
<i>U.S. Term Limits v. Thornton</i> , 115 S. Ct. 1842 (1995)	28
CONSTITUTIONAL PROVISIONS	
U.S. Const. amend. X	28
OTHER AUTHORITIES	
100 Chest 1619-1636 (1991)	19
115 Can. Med. Ass'n J. 125-129 (1976)	7
117 Ann. Internal Med. 949 (1992)	11
119 Ann. Internal Med. 121-126 (1993)	12
152 Am. J. Psychiatry 1185-1190 (1995)	24
163 West J. Med. 302-305 (1995)	10
247 JAMA 2793-2797 (1982)	6
263 JAMA 1097-1101 (1990)	22
273 JAMA 1039-1043 (1995)	2
274 JAMA 1591-1598 (1995)	7
275 JAMA 474-478 and 919-925 (1996)	5, 10, 23
319 New Eng. J. Med. 1635-1638 (1988)	22
328 New Eng. J. Med. 964-966 and 1092-1096 (1993)	7
39 J. Chronic. Dis. 47-62 (1986)	7, 17
42 J. Am. Geriatrics Soc'y 1202-1207 (1994)	20
43 J. Am. Geriatrics Soc'y 553-562 and 577-580 (1995)	2, 11, 14
44 J. Am. Geriatrics Soc'y 553 (1996)	26
4 Pain Forum 163-178 (1995)	10
56 J. Consult. Clin. Psychol. 509-513 (1988)	23
5 J. Clin. Ethics 23-30 (1994)	9

TABLE OF AUTHORITIES—Continued

	Page
76 Cancer 1283-1293 (1995)	8
8 J. Pain Symptom Mgmt. 353-360 (1993)	8
9 J. Gen Internal Med. 146a (1994)	24
35 Duquesne L. Rev. 159-181, 311-336 and 443-453 (1996)	12, 19, 27
320 New Eng. J. Med. 433-439 (1989)	9
317 New Eng. J. Med. 1281-1285 (1987)	9
306 New Eng. J. Med. 99 (1982)	13
35 The Gerontologist 119-121 (1995)	7
334 New Eng. J. Med. 310-315 (1996)	25-26
335 New Eng. J. Med. 172-178 and 201-202 (1996)	17
10 J. Pain Symptom Mgmt. 131-141 (1995)	22
151 Am. J. Psychiatry 1631-1636 (1994)	22
Cicely Saunders et al., <i>A Guide to Palliative Care</i> 23 (3rd ed. Oxford University Press 1995)	13
Clive Seale, Ann Cartwright, <i>The Year Before Death</i> 186 (Ashgate Publishing Company 1994) ..	12
Marilyn Moon, <i>Medicare Now and in the Future</i> (2d ed. The Urban Institute Press 1996)	2, 24
Joshua M. Wiener, <i>Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance</i> (1994)	2
W. Breitbart, <i>Suicide Risk and Pain in Cancer and AIDS Patients in: Current and Emerging Issues in Cancer Pain: Research and Practice</i> , 49-65 (C.R. Chapman & K.M. Foley 1993)	6, 8, 12, 22, 23
John J. Bonica, <i>Cancer Pain in: The Management of Pain</i> , vol. 1, 400-460 (John J. Bonica ed. 1990)	7
World Health Organization, <i>Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee</i> . WHO Technical Report Series, No. 809 (World Health Organization 1990)	8
W. Osler, <i>Science and Immortality</i> (The Riverside Press 1904)	9
Derek Doyle, et al., eds., <i>Oxford Textbook of Palliative Medicine</i> , 4 (Oxford University Press 1993)	9

TABLE OF AUTHORITIES—Continued

	Page
Alan Meisel, <i>The Right to Die</i> (2nd ed. John Wiley & Son 1995)	9, 14
The Hastings Center, <i>Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying</i> (Indiana University Press 1987)	11
Timothy Egan, <i>As Memory and Music Faded, Oregon Woman Chose Death</i> , N.Y. Times, June 7, 1990, A 1:2	12
American Pain Society, <i>Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain</i> , 23 (3rd ed. American Pain Society 1992) ..	13
Courtney Campbell, et al., <i>Conflicts of Conscience: Hospice and Assisted Suicide</i> , Hastings Center Report 36-43 (May-June 1995)	16
Charles H. Baron, et al., <i>A Model State Act to Authorize and Regulate Physician-Assisted Suicide</i> , 333 Harvard Journal on Legislation 1-34 (Winter 1996)	16
English and Meisel, <i>Uniform Health-Care Decision Act Gives New Guidance</i> , 21 Estate Planning 355, 359 (1994)	17
The Center for the Evaluative Clinical Sciences, Dartmouth Medical School, <i>The Dartmouth Atlas of Health Care</i> (AHA Publishing 1996)	24
R. Sean Morrison & D. E. Meier, <i>Physician-Assisted Dying: Fashioning Public Policy with an Absence of Data</i> , <i>Generations</i> 48-53 (Winter 1994)	10
New York State Task Force on Life and the Law, <i>When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context</i> 102 (May 1994)	11
P. J. Van der Maas et al., <i>Euthanasia and Other Medical Decisions Concerning the End of Life</i> , 338 Lancet 669-674 (1991)	23, 27
U.S. Bureau of the Census, <i>Statistical Abstract of the United States: 1995</i> , 86 (115th ed. 1995)	5
J. Lynn ed., <i>By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water</i> (Indiana University Press 1989)	7

TABLE OF AUTHORITIES—Continued

	Page
V. Mor, et al., <i>The Hospice Experiment: An Alternative in Terminal Care</i> in: <i>THE HOSPICE EXPERIMENT</i> 1-15 (Vincent Mor, et al., eds; 1988) ..	8
President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, <i>Deciding to Forego Life-Sustaining Treatment</i> (March 1983)	11
American Board of Internal Medicine, <i>Caring for the Dying: Identification and Promotion of Physician Competency</i> (American Board of Internal Medicine 1996)	12
<i>The American Geriatrics Society's Complete Guide to Aging & Health</i> , 119 (Harmony Books 1995) ..	13
Oregon Death with Dignity Act, Ballot Measure 16 (passed Nov. 8, 1994)	16
J.G. Brown, <i>Review Of Medicare Hospice Beneficiary Eligibility In The Commonwealth Of Puerto Rico</i> (DHHS, OIG, March 1996)	17
Standards and Accreditation Committee, Medical Guidelines Task Force, <i>Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases</i> (2nd ed. National Hospice Organization 1996)	17
Carl Eisdorfer, et al., eds., <i>Caring for the Elderly: Reshaping Health Policy</i> (The Johns Hopkins University Press 1989)	2
National Center for Health Statistics, <i>Vital Statistics of the United States, 1991, Vol. 2, Mortality, Part A, Sec. 1</i> , Washington, D.C.: GPO 1996: 380-1 (DHHS publication no. (PHS) 96-1101) ..	6, 9
Lewis Thomas, <i>The Lives of a Cell</i> (Bantam Books 1974)	7
Guidelines for State Court Decisionmaking in Life-Sustaining Medical Treatment Cases, A Project of the National Center for State Courts (2d ed., West Pub. Co. 1993)	11
Uniform Health-Care Decisions Act, National Conference of Commissioners on Uniform State Laws (1993)	16

TABLE OF AUTHORITIES—Continued

	Page
122 Ann. Internal Med. 191-203 (1995)	19
A. Scitovsky, "The High Cost of Dying Revisited," 72 Milbank Mem. Fund. Q. Health Soc. 561-591 (1994)	24

INTEREST OF AMICUS CURIAE¹

The American Geriatrics Society (AGS) is comprised of professional health care providers focused upon serving the health care needs of elderly persons. Founded in 1942, the AGS has 6,000 dues-paying members. The AGS sponsors conferences and seminars, articulates policy and practice guidelines, publishes a preeminent professional journal (*The Journal of the American Geriatrics Society*), and encourages improved health care services for elderly persons and research on the illnesses from which they suffer. As practitioners specializing in the care of the elderly, AGS members are particularly dedicated to improving how people live at the end of life and consequently have abiding concerns with the issues raised by initiatives to legalize physician-assisted suicide (PAS).

The AGS and its members have worked diligently to assure that even elderly persons with severe dependency and limited personal and family resources can count on reliable and effective diagnosis, treatment, prevention, rehabilitation and supportive care. The AGS has encouraged care providers, the elderly, and their families to adopt an optimistic and energetic approach to treatment of illness. However, geriatricians (including physicians, nurse practitioners, and other health-care professionals) also realize that all elderly persons die, and that serving people well in their old age requires incorporating that fact into judging various strategies for care. Just as we must strive to make available all potentially beneficial treatment, we must also strive to avoid interventions that are more harmful than beneficial.

Legalization of PAS would create a moral dilemma for geriatricians. Most elderly persons experience serious and

¹ Each party has given its consent, in writing, to the filing of this brief amicus curiae. Their consent letters have been filed with the Clerk of the Court. Counsel gratefully acknowledges the valuable contributions made to this brief by Joanne Lynn, M.D., and Felicia Cohn, Ph.D. Dr. Lynn, a recognized authority on the care of the dying, is a board member of the AGS and chair of its Ethics Committee. Dr. Cohn is associated with Dr. Lynn in the Center to Improve the Care of the Dying.

progressive illness for extended periods before death and need significant social, financial and medical supports.² These resources too often are not available, are of inadequate quality, are not covered by insurance, and are not provided by public entitlement programs.³ By collaborating in causing early deaths, when continuing to live has been made so difficult, geriatricians would become complicit in a social policy which effectively conserves community resources by eliminating those who need services. By refusing to assist with suicides because a patient's relative poverty and disadvantaged social situation is seen as coercive, geriatricians would condemn their patients, and themselves, to live through the patients' undesired difficulties for the time remaining.

This conundrum has prevented defining a defensible role for geriatricians in any legalized practice of PAS. These concerns have driven the members of the AGS to address this issue at a time when few professional organizations have done so. The AGS position statements on PAS and euthanasia are attached.⁴ The AGS opposes legalization of PAS at this time. Elderly and frail persons would be put at risk, yet their interests and concerns have not been adequately addressed in the public discussion of these issues.

² Marilyn Moon, *Medicare Now and in the Future* (2nd ed. The Urban Institute Press 1996); see also Jack D. McCue M.D., *The Naturalness of Dying*, 273 JAMA 1039-1043 (1995).

³ Joshua M. Wiener, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance* (1994); Marilyn Moon, *Medicare Now and in the Future* (2d ed. 1996); Carl Eisdorfer et al., eds., *Caring for the Elderly: Reshaping Health Policy* (The Johns Hopkins University Press 1989).

⁴ See Appendix and AGS Ethics Committee, *The Care of Dying Patients*, 43 J. Am. Geriatrics Soc'y 577-578 (1995); AGS Ethics Committee, *Physician-Assisted Suicide and Voluntary Active Euthanasia*, 43 J. Am. Geriatrics Soc'y 579-580 (1995). See also Greg A. Sachs, M.D., et al., *Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia*, 43 J. Am. Geriatrics Soc'y. 553-562 (1995).

The AGS urges this Court to note that improving life at its end has only recently become the subject of research and innovation. The potential consequences of accepting or tolerating PAS are unknown. The AGS believes that continued debate on these issues is essential if there is to be wise policy. The AGS takes no position on the merits of PAS for the patients in the cases before the Court. Instead, the AGS urges this Court not to recognize a constitutional right to the practice of PAS. At this time, the Court should exercise restraint in deciding a matter that would be more appropriately left to the states and the people. The AGS adopts the legal argument advanced in the *amicus* brief of the Project on Death in America of the Open Society Institute, which contends that the matter is not yet ripe for constitutional adjudication. The AGS limits this *amicus* brief to a presentation of a medical perspective on the uncertainties that require study and resolution before PAS could be implemented as the policy of any jurisdiction, or recognized as a constitutional right.

SUMMARY OF ARGUMENT

The courts for the Second and Ninth Circuits relied on three serious misperceptions in overturning state laws prohibiting PAS.⁵ First, the courts were misinformed as to how people live while dying in the United States. Contrary to the courts' apparent assumptions, the plaintiff-patients in *Quill* and *Compassion in Dying* do not represent the usual situation of persons facing the end of life; severe pain and other symptoms can be relieved for persons near death; and health care generally and at the end of life is undergoing major changes.

Second, the lower courts mistakenly concluded that there is no significant difference between PAS and foregoing life-sustaining treatment. From a medical standpoint, however, clinical, definitional, and procedural considerations reveal important distinctions. These differences add

⁵ *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

to the legal, ethical, and historical distinctions identified by this court in *Cruzan*.⁶

Third, the courts below mistakenly condition their holdings upon the erroneous assumption that six restrictive criteria or safeguards can be easily identified and implemented: that the patients be (a) terminally ill, (b) competent, (c) suffering, (d) acting voluntarily and (e) seeking assistance in obtaining a means of suicide (f) which will be available only from a physician. In fact, as the discussion that follows makes clear, the medical profession has no adequate definitions for some of these criteria and lacks experience with all of them, making it unreasonable to believe that legislatures or courts could easily design procedures to ensure that each criterion could be met and could be sustained.

In view of the misperceptions upon which the decisions below were based, and the dearth of experience and knowledge that would be necessary to implement the exercise of a right to PAS, the AGS respectfully submits that a decision by this Court to constitutionalize PAS would be, at best, seriously premature.

ARGUMENT

I. THE COURTS WERE MISLED BY MISPERCEPTIONS ABOUT END-OF-LIFE EXPERIENCES.

A. The Patient-Plaintiffs Are Not Representative of Dying Persons Generally.

The named patients in the cases before the Court are dying in ways that do not characterize how people generally die in the United States. The identified patients all have a single, well-defined disease: three suffer from AIDS, two from cancer, and one from emphysema. Their situations thus fail to reflect the multiple diseases and uncertain prognoses that are much more common in advanced old age. Patient-plaintiffs' ages average 56 years. Not

⁶ *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

one of the named plaintiffs is as old as the median age of death in the United States, 77 years.⁷ None is characterized as poor, without family, or living in nursing homes. All have physicians, and none mention problems of access due to inadequate health insurance. This sample thus falls far short of representing the array of problems and concerns which should inform a determination of the constitutionality, or even the wisdom, of allowing PAS. The relative simplicity of the medical and social situations of these patients appears to have misled the lower courts into believing that PAS is the only or best response to those patients' problems.

Much has changed about how people come to the end of their lives in the United States. No more than a century ago, dying afflicted every decade of adult life, nearly evenly.⁸ The most common causes of death were infections and accidents, which generally allowed little time between onset and death. Even cancer and heart disease were discovered late and the lack of effective treatment meant that death often occurred shortly after diagnosis.

Average life spans have also increased. Now, median life expectancy is 79 for women and 72 for men. Among those who survive to age 65, median age at death is 84 for women and 80 for men.⁹ The usual causes of death now include cancer, heart disease, other organ system failures, and dementia, all of which are illnesses that ordinarily cause progressive disability over more than a year.¹⁰ Typically, persons dying in their eighties and older succumb to a combination of loss of reserve capacity in aging

⁷ Projection for the year 2000 is 76.7 years. See U.S. Bureau of the Census, *Statistical Abstract of the United States: 1995*, 86 (115th ed. 1995).

⁸ Council on Scientific Affairs, American Medical Association, *Good Care of the Dying Patient*, 275 JAMA 474-478 (1996).

⁹ Reports for 1993 for median life expectancy from birth, and for 1992 for median life expectancy at age 65. *Supra* note 7.

¹⁰ See note 8, *supra*.

organs, deficiencies in daily functioning, and diseases with specific etiology.¹¹

Modern society must learn how to assure that dependent and disabled persons can live well, despite living for a long time with eventually fatal illnesses. Prognosis is ordinarily uncertain. Poverty and isolation are common. Nearly one in five dies in a nursing home.¹² Depression and other psychiatric problems are common and largely unrecognized.¹³ Characterizing the issue as simply acquiescing in the patient's request to end his suffering, as the courts below did, is much more difficult when one imagines a slowly failing elderly widow who is blind, nearly deaf, disabled, and in a Medicaid nursing home, than when the claimant is a younger patient with a predictably fatal illness.

B. Dying Is Mischaracterized as Unavoidably Dreadful.

Contrary to the apparent assumptions of the courts below, fatal illness does not have to mean severe pain and suffering. The Ninth Circuit's opinion repeatedly describes dying as "painful, protracted, and agonizing."¹⁴ The Ninth Circuit then contrasts this fate with death by assisted suicide which lets a patient: "end his life peacefully and with dignity."¹⁵

¹¹ R.R. Kohn, *Cause of Death in Very Old People*, 247 JAMA 2793-2797 (1982).

¹² National Center for Health Statistics, *Vital Statistics of the United States, 1991*, Vol. 2, Mortality, Part A. Sect. 1, Washington, D.C.: Government Printing Office, 1996:380-1. (DHHS publication no. (PHS) 96-1101).

¹³ W. Breitbart, *Suicide Risk and Pain in Cancer and AIDS Patients* in: CURRENT AND EMERGING ISSUES IN CANCER PAIN: RESEARCH AND PRACTICE, 49-65 (C.R. Chapman & K.M. Foley 1993).

¹⁴ *Compassion in Dying*, 79 F.3d at 839; see also *id.* at 812.

¹⁵ *Id.* at 824. See also *id.* 814: "... a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent."

However, most people die quietly, most often in their sleep.¹⁶ Hospice and palliative care programs have demonstrated that no dying person must live with overwhelming pain or other severe physical symptoms. Severe and persistent pain affects about half of cancer patients¹⁷ and one quarter of dying persons generally.¹⁸ Sophisticated palliative care relieves pain for most of these patients without confusion or substantial sedation. Intractable pain that can be relieved only by inducing sedation afflicts less than 3%, mostly very near the end of life.¹⁹ Aggressive palliative care and sedation near death are already permissible. So is the removal of artificial nutrition and hydration²⁰ that were mentioned as sustaining two of the plaintiff-patients.

However, the standard of care lags behind what is possible to achieve, due both to barriers meant to limit the availability of narcotics and to delay in the adoption of

¹⁶ D.J. Foley, et al., *Recounts of Elderly Deaths: Endorsements for the Patient Self-Determination Act*, 35 The Gerontologist 119-121 (1995); "I have seen agony in death only once, in a patient with rabies," Lewis Thomas, *The Lives of a Cell* (Bantam Books 1974).

¹⁷ John J. Bonica, *Cancer Pain* in: THE MANAGEMENT OF PAIN, vol. 1, 400-460 (John J. Bonica ed. 1990).

¹⁸ The SUPPORT Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591-1598 (1995).

¹⁹ T.E. Quill, et al., *Assisted Death And Physician-Assisted Suicide* 328 New Eng. J. Med. 965-966 (1993); J. Lynn, *Assisted Death and Physician-Assisted Suicide* 328 New Eng. J. Med. 964 (1993); see also R. Melzack, et al., *The Brompton Mixture: Effects On Pain In Cancer Patients*, 115 Can. Med. Ass'n J. 125-129 (1976); J.N. Morris, et al., *Last Days: A Study Of The Quality Of Life Of Terminally Ill Cancer Patients*, 39 J. Chronic. Dis. 47-62 (1986).

²⁰ *Cruzan*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976); see also J. Lynn ed., *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water* (Indiana University Press 1989).

better practices by the health care professions.²¹ Public policy should more vigorously encourage reliable relief of symptoms, but PAS is never the only option to relieve uncomfortable symptoms in a person near death.

How society arranges services to support care of those at the end of life has profound effects upon how that life can be lived. Life just before death can be especially precious and important. When supported and comfortable, dying persons ordinarily accomplish important tasks, such as saying farewells, disposing of property, completing life projects, and enjoying their remaining days. The courts below do not seem to have taken account of this possibility. See, e.g., *Quill*, 80 F.3d at 729.

Many persons consider suicide or wish for early death while they are angry or suffering. Since persons feeling worthless often test others to see whether these views are shared, encountering agreement actually functions to affirm the denigration of value. To offer PAS at this time does not merely offer an option but also affirms feelings of worthlessness or devaluation.²² Since, when comfortable and comforted, most patients feel that this was an unexpectedly important time,²³ encouraging supportive care

²¹ D.E. Joranson, *Availability of Opioids for Cancer Pain: Recent Trends, Assessment of System Barriers, New World Health Organization Guidelines, and the Risk of Diversion*, 8 J. Pain Symptom Mgmt. 353-360 (1993); see also N.J. Cherny, et al., *Opioid Pharmacotherapy in the Management of Cancer Pain: A Survey of Strategies Used by Pain Physicians for the Selection of Analgesic Drugs and Routes of Administration*, 76 Cancer 1283-1293 (1995); World Health Organization, *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee*. WHO Technical Report Series, No. 809 (World Health Organization 1990).

²² "[I]n agreeing to euthanize or assist a patient in suicide, one may be confirming the patient's sense that life has no more meaning or purpose, and this may be the wrong message to convey at such a vulnerable period in the patient's life." Breitbart, *supra* note 13, at 61.

²³ *The Hospice Experiment: An Alternative in Terminal Care* in: THE HOSPICE EXPERIMENT, 1-15 (Vincent Mor, et al., eds., 1988).

and discouraging suicide seems well within the purview of wise public policy.

C. The Lower Courts Misperceived Current Shortcomings in Care at the End of Life as Persistent and Unchanging.

Discussions about PAS are clouded by the paucity of reliable information regarding death in the United States.²⁴ Nevertheless, this is clearly a time of great ferment. Research in palliative care has developed considerably in the past twenty years.²⁵ About 61% of Americans die in hospitals and 17% in nursing homes, with the proportion of deaths in nursing homes increasing and those in hospitals decreasing.²⁶ In 1970, the standard of practice was to attempt resuscitation for virtually every person who died.²⁷ Now, foregoing life-sustaining treatment is commonplace,²⁸ especially for those with poor prognoses for survival. Resuscitation is now attempted for only about 10% of seriously ill persons who die in hospitals.²⁹ In the past, treatments were often continued for patients with poor prognoses and small chances of recovery.³⁰

²⁴ Indeed, the only description of sequential seriously ill patients dying in hospitals in the United States was done in 1904. W. Oaler, *Science and Immortality* (The Riverside Press 1904). See also *supra* note 8.

²⁵ Derek Doyle, et al., eds., *Oxford Textbook of Palliative Medicine*, 4 (Oxford University Press 1993). One recent study of certain seriously ill persons in hospitals has been influential, but it addressed only a small subset of the dying, *supra* note 18.

²⁶ M.A. Sager, et al., *Changes In Location Of Death After Passage Of Medicare's Prospective Payment System: A National Study*, 320 New Eng. J. Med. 433-439 (1989); *supra* note 12.

²⁷ Leslie J. Blackhall, *Must We Always Use CPR?* 317 New Eng. J. Med. 1281-1285 (1987); *In re Quinlan*, 355 A.2d 657 (N.J. 1976); Alan Meisel, *The Right to Die* (2d ed. John Wiley & Son 1995).

²⁸ J.M. Teno, et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resources for the Seriously Ill Patients?*, 5 J. Clin. Ethics 23-30 (1994).

²⁹ *Supra* note 18.

³⁰ E.g., *Cruzan*, 497 U.S. 261.

It is important to consider the major changes that are now reshaping health care generally. The rise of managed or capitated arrangements for service delivery and financing and the shift toward competing on costs rather than quality are rearranging relationships and roles. The impact on end-of-life care is not yet clear, but it is likely to include more reluctance to provide expensive care or to encourage patients and families to seek prolonged survival.³¹

The lower courts accepted a descriptive claim that PAS already exists as a clandestine but widely acknowledged practice.³² AGS leadership is not familiar with situations in which this is true, and it seems unlikely. Three-quarters of all deaths happen in institutions where a regularized practice would require the collusion of a large number of persons, which seems implausible. Little reliable evidence characterizes the rate and nature of actual instances of PAS.³³ Courts should not rely upon presumptions and unsubstantiated reports in such a matter.

The constitutionality of PAS should not be resolved by reference to atypical situations and reliance upon misperceptions, as happened in these cases. Consideration of the role of PAS must be part of a broader examination of how this society should care for people with fatal illness and is therefore an endeavor more properly undertaken

³¹ S.H. Miles, et al., *End Of Life Treatment In Managed Care. The Potential And The Peril*, 163 West J. Med. 302-305 (1995).

³² *Compassion in Dying*, 79 F.3d at 801, 828.

³³ All surveys of physician practices or attitudes are of limited validity due to low response rates, biased questions, or potential violations of confidentiality. Some insight is available in: A. L. Back, *Physician-Assisted Suicide And Euthanasia In Washington State. Patient Requests And Physician Response*, 275 JAMA 919-925 (1996); see also review of surveys in: K.M. Foley, *Pain, Physician-Assisted Suicide, and Euthanasia*, 4 Pain Forum 163-178 (1995); R. Sean Morrison & Diane E. Meier, *Physician-Assisted Dying: Fashioning Public Policy with an Absence of Data*. Generations 48-53 (Winter 1994).

by state legislatures and professional and lay organizations than by the federal judiciary.

II. THE COURTS BELOW MISTAKENLY CONCLUDED THAT PHYSICIAN ASSISTED SUICIDE IS NO DIFFERENT FROM FOREGOING LIFE-SUSTAINING TREATMENT.

The lower courts erred in finding no justification for distinguishing PAS from foregoing (withdrawing and withholding) life-sustaining treatment (FLST). However, significant medical, legal, and societal distinctions exist between the two practices and fatally undermine the conclusion that they are entitled to the same legal status. The AGS defines PAS as "[w]hen a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the sole purpose of assisting the patient to end his or her own life." FLST is defined as "[w]hen medical intervention is either not given or the on-going use of the intervention is discontinued, allowing natural progression of the underlying disease state."³⁴ Major American medical associations and public committees and commissions³⁵ have recognized the distinctions between PAS and FLST.

³⁴ AGS Ethics Committee, *PAS and Voluntary Active Euthanasia*, 43 J. Am. Geriatrics Soc'y 579-580 (1995), which is printed in the appendix.

³⁵ *American College of Physicians Ethics Manual*, 3rd ed. 117 Ann. Internal Med. 947-960 at 949 (1992); New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 102 (May 1994); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (March 1983); see also The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Indiana University Press 1987); *Guidelines for State Court Decisionmaking in Life-Sustaining Medical Treatment Cases, A Project of the National Center for State Courts* (2d ed., West Publishing Company 1993).

A. Descriptive Aspects Differentiate the Two Situations.

In addition to definitional differences and historical precedent, the situations involving PAS and FLST are associated with important moral and practical differences, including differences in access to medical care, in the practical effects of decisions, and in clinical intent.

Patients wishing to forego treatment are generally already receiving medical attention, and they have life-sustaining treatment available if desired. Thus, FLST decisions are implemented only when the life-sustaining treatment is unwarranted. However, for those seeking PAS, suicide may become a substitute for valuable but inaccessible medical attention. Persons seeking PAS may not know about, nor have available, other options for treatment, whether because of financial need, because their physician has inadequate skills,³⁶ or because social or ethnic barriers intervene.

Patients receiving life-sustaining treatment are usually very sick and close to death, so that even aggressive intervention is unlikely to lengthen their lives appreciably. With PAS, however, an individual may be giving up a more extended period of life. Fear of suffering and of losing dignity, along with a desire to control circumstances of death, may prompt a request for assistance in suicide before suffering might become unbearable.³⁷

³⁶ J.H. Von Roenn, et al., *Physician Attitudes and Practice in Cancer Pain Management—A Survey from the Eastern Cooperative Oncology Group*, 119 Ann. Internal Med. 121-126 (1993); see also Clive Seale, Ann Cartwright, *The Year Before Death* 186 (Ashgate Publishing Company 1994); American Board of Internal Medicine, *Caring for the Dying: Identification and Promotion of Physician Competency* (American Board of Internal Medicine 1996).

³⁷ Timothy Egan, *As Memory and Music Faded, Oregon Woman Chose Death*, N.Y. Times, June 7, 1990, at A 1:2; see also Marshall B. Kapp, *Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 Duquesne L. Rev. 445-455 (1996); see also Breitbart, *supra* note 13.

In FLST, the intent is not to bring about the patient's death but to respect the patient's wishes not to be subjected to undesired treatment. Once medical treatment is withdrawn or withheld, the underlying disease process usually leads to the patient's death, though some survive. Although a physician sometimes physically removes the life support, the underlying disease and not the physician's action is ordinarily considered the cause of death. Failure to remove the undesired treatment would amount to battery, an unconsented touching. In PAS, the physician may be acting in accord with the patient's wishes, but death results from a drug overdose rather than a natural course of dying.

The Second Circuit's opinion also appears to suggest that PAS follows from aggressive pain management (80 F.3d at 729). Good pain management, however, usually prolongs life, and even very high doses of opioids rarely cause respiratory depression in patients who have been taking them for more than a few days.³⁸ Further, good palliative care aims to eliminate the suffering, whereas PAS succeeds only by eliminating the sufferer.

B. Rights Against Interference Are Stronger Claims Than Those for Assistance.

This Court has established that patients have the authority to forego life sustaining treatment, based on the requirement that the patient's informed consent is required for medical intervention.³⁹ The authority to

³⁸ "Respiratory depression. This rarely presents a problem if the oral morphine dose is titrated carefully against the patient's pain, for pain is a respiratory stimulant. Tolerance to respiratory depression develops rapidly so that high doses of morphine can be used if necessary, without significant risk." Cicely Saunders et al., *Living with Dying: A Guide to Palliative Care* 23 (3rd ed. Oxford University Press 1995); see also American Pain Society, *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 23 (3rd ed. American Pain Society 1992; Marcia Angell, M.D., *The Quality of Mercy*, 306 New Eng. J. Med. 99 (1982).

³⁹ *Cruzan*, 497 U.S. 261 (1990). See also *In re Quinlan*, 355 A.2d 647 (1976); Mark E Williams, M.D., *The American Geriatrics*

forego life-sustaining treatment is thus a right to prevent unwanted bodily intrusion. Withdrawing or withholding a treatment to honor the patient's refusal of consent is not a matter of providing a patient with assistance but one of leaving the patient alone. Physicians may not impose treatment on a patient who refuses that treatment, even if the physician believes that the treatment will benefit the patient. This right to be left alone does not imply any corollary right to receive a form of assistance such as PAS.

C. The Restriction of Physician Assisted Suicide to a Narrow Class of Persons Highlights Its Differences From Foregoing Life-Sustaining Treatment.

FLST is an option for all treatments and all patients, just like any other medical decision. If PAS were equivalent to FLST, it should be available to all patients. Yet both courts below and all current legislative proposals restrict the right to PAS to a certain category of patients—those that are terminally ill, competent, acting voluntarily, and suffering. Unlike FLST, no proposal allows PAS to be directed in advance or by surrogate decision makers. The uniform agreement on such restrictions clearly suggests that the courts, the legislatures, and the policymakers recognize clear distinctions between PAS and FLST.

D. The History of Familiarity With Foregoing Life-Sustaining Treatment Contrasts Sharply With the Lack of Experience With Physician Assisted Suicide.

As this Court recognized in *Cruzan*, the right to reject life-sustaining medical treatment has had a long history of public acceptance, from legal, ethical, and medical perspectives.⁴⁰ Rooted in the common law doctrine of informed consent and recognized by courts, legislatures,

Society's Complete Guide to Aging & Health, 119 (Harmony Books 1995); *supra* note 34.

⁴⁰ *Cruzan*, 497 U.S. 261 (1990); see also *In re Quinlan*, 355 A.2d 647 (1976); see also Alan Meisel, *The Right to Die* (2d ed. 1995).

and the health care professions, a consensus has emerged that persons generally have the right to refuse medical interventions, even though death may result.

In sharp contrast, no such consensus surrounds the practice of PAS. It has no common-law basis and has not been recognized widely by courts, legislatures, the public, or the medical profession. Most states have statutes prohibiting the practice of PAS—similar to the New York and Washington statutes struck down by the courts below in these cases. The practice has been approved by the voters in only one state, Oregon, where an initiative passed by a narrow margin but has not yet been implemented. The lack of any substantive experience with PAS, and the myriad restrictions attached to every proposed formulation of a right to request it, show that PAS is considered quite differently by all—its proponents, the law, health care providers, and the public.

III. THE CONSTRAINTS PROPOSED FOR THE PRACTICE OF PHYSICIAN ASSISTED SUICIDE PRESENT INTRACTABLE PROBLEMS.

As noted above, the plaintiffs below sought PAS only for a limited class of persons. Accordingly, the right to assisted suicide recognized in both cases is confined to adult patients who have terminal illnesses; are mentally competent; suffer from chronic and/or severe pain; and make a voluntary request for PAS. In addition, the only authorized method of assistance is through a physician's prescription of lethal medication which the patient must self-administer.

The Second and Ninth Circuits found a constitutional right to PAS conditioned upon these criteria, which they assumed would also function as safeguards to prevent mistakes or abuse. As the discussion below demonstrates, however, those decisions were based upon erroneous assumptions about the feasibility of both defining and applying the eligibility criteria. In fact, if PAS were to be implemented, determining the eligible population

would be intractably difficult and the proposed constraints would likely fail to provide the safeguards upon which the lower courts' decisions were based.

A. Terminal Illness.

Various statutory proposals and the cases before this Court contemplate that PAS will be authorized only for those who are "terminally ill."⁴¹ The opinions below suggest that limiting the category to "terminal illness" helps to make the shortening of life acceptable and presume that the category can be clearly delineated. The Second and Ninth Circuits dismissed arguments asserting the difficulty of determining when a patient is "terminally ill," noting that "terminal illness" and "terminal condition" have been "defined repeatedly . . . in a model statute, the Uniform Rights of the Terminally Ill Act, and in over 40 state natural death statutes."⁴² In actuality, such judgments are notoriously difficult to make. Indeed, because terminal illness or terminal condition is so difficult to define, the new Uniform Health-Care Decisions Act,⁴³ which supersedes the Uniform Rights of the Terminally Ill Act, upon which the Ninth Circuit partially relied, omits any reference to terminal condition

⁴¹ Courtney Campbell, et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, Hastings Center Report 36-43 (May-June 1995); Charles H. Baron, et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 333 Harvard Journal on Legislation 1-34 (Winter 1996); Oregon Death with Dignity Act, Ballot Measure 16 (passed Nov. 8, 1994); *Quill*, 80 F.3d at 731; *Compassion in Dying*, 79 F.3d at 838.

⁴² "[W]hile defining the term 'terminally ill' is not free from difficulty, the experience of the states has proved that the class of terminally ill is neither indefinable nor undefined," *Compassion in Dying*, 79 F.3d at 831. See also *Quill*, 80 F.3d at 731 (stating that "it seems clear that most physicians would agree" on when the condition of "final stages" of terminal illness occurs).

⁴³ Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws at its conference held July 30-August 6, 1993, and approved by the American Bar Association on February 7, 1994.

and does not attempt to define terminal illness. The reasons for this omission have been explained as follows by David English, the reporter for this new Uniform Act: "Most existing advance directive legislation becomes effective only if a patient is in a 'terminal condition,' or is 'permanently' unconscious. Such restrictions have severely limited the usefulness of many state statutes and, indeed, have rendered them virtual nullities."⁴⁴

As the drafters of this new Uniform Act thus recognized, terminal illness is notoriously difficult to define, and the working definitions of "terminal illness" for hospice or advance directive legislation are neither relevant nor reassuring, as the courts below erroneously concluded.

Hospice programs, for example, enroll mostly persons with some particular cancers.⁴⁵ Referral to hospice is most often initiated when such a patient experiences a deterioration in function, weight and comfort, usually three to six weeks ahead of death.⁴⁶ For cancer, then, the clinical course dictates timing, which is much shorter than the hospice statutory prognosis requirement of six months. Other illnesses do not regularly have such a final, relatively distinct, phase of clinical deterioration and they are engendering problems when referred into hospice.⁴⁷

⁴⁴ See English and Meisel, *Uniform Health-Care Decision Act Gives New Guidance*, 21 Estate Planning 355, 359 (1994).

⁴⁵ N.A. Christakis & J.J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172-178 (1996).

⁴⁶ J. Lynn, *Caring At The End Of Our Lives*, 335 New Eng. J. Med. 201-202 (1996); J.N. Morris et al., *Last Days: A Study Of The Quality Of Life Of Terminally Ill Cancer Patients*, 39 J. Chronic Dis. 47-62 (1986).

⁴⁷ Hospice programs are being scrutinized by the Dept. of Health and Human Services' Office of the Inspector General, with disagreements on prognosis as hospice expands to enroll patients dying of chronic diseases. J.G. Brown, *Review Of Medicare Hospice Beneficiary Eligibility In The Commonwealth Of Puerto Rico* (DHHS, OIG, March 1996). See also Standards and Accreditation Commit-

A more rigorous definition of terminal illness seems necessary for PAS, since PAS has such significant and irreversible consequences. Three general approaches might be used in attempting to define the category "terminally ill": subjective judgment, statistical criteria, or a disease severity threshold. An examination of each of these reveals crippling problems.

1. Subjective Determination.

Some person or persons could be designated to judge whether a patient is "terminally ill," using information about the patient's situation, prognosis, care needs, and preferences. At present, the patient, family, and professional caregivers negotiate the designation while discussing plans and making decisions. The label then marks a change from a strategy of correcting abnormalities with the expectation of long survival to a strategy focusing on function, comfort, and emotional and spiritual support with the expectation of death.

In routine patient care, the timing of this change in focus does not much matter. The various participants can arrive at the designation at somewhat different times. However, the obvious variation in and diffuseness of this process would be troubling in the context of determining eligibility for authorizing PAS, and the fact that availability of PAS would be contingent on a designation of being terminally ill may result in pressure to accelerate or resist the label.

2. Statistical Determination.

Defining terminal illness with an explicit statistical threshold seems to offer clarity: a person is either below or above that threshold. However, this approach fails as it encounters at least four serious barriers.

First, the data necessary to calculate estimates which can be compared with a legislated statistical threshold is

tee, Medical Guidelines Task Force, *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases* (2d ed. National Hospice Organization 1996).

only rarely available. Very little research addresses the issue.⁴⁸ Most people will die of conditions that are not predictable with a statistical model.⁴⁹

Second, the threshold is unavoidably arbitrary, with many borderline cases and unavoidable errors of over-inclusion and underinclusion. Any threshold will include people who will live a long time; the rate increases with more inclusive thresholds. A population in which each person has exactly a 25% chance to live six months will have one in four persons still alive at six months. The threshold should include all who will soon die of a serious chronic disease. However, some diseases are intrinsically unpredictable, even very close to death.⁵⁰ No reason justifies setting the threshold at any particular point, thus rendering any threshold arbitrary and subject to dispute.

Third, any specific threshold is inconsistent with current usage of the category. The popular conception of "termi-

⁴⁸ APACHE III and similar systems estimate the risks of dying during a particular hospitalization for very seriously ill patients in hospital intensive care units. W.A. Knaus et al., *The APACHE III Prognostic System. Risk Prediction of Hospital Mortality for Critically Ill Hospitalized Adults*, 100 Chest 1619-1636 (1991). SUPPORT's formula allows estimation of survival throughout the ensuing six months, but only for certain seriously ill patients with nine specific diseases, treated in hospitals. W.A. Knaus, et al., *The SUPPORT Prognostic Model: Objective Estimates of Survival for Seriously Ill Hospitalized Adults*, 122 Ann. Internal Med. 191-203 (1995). Other available formulae are even more restricted in population, setting, or data required.

⁴⁹ The estimate varies also because other predictions can arise from one research database.

⁵⁰ Prognoses are surprisingly optimistic very near to death. Lung cancer patients in one study had a median prognosis of 17% to live two months on the day before death, and 50% just one week before death. Those dying of congestive heart failure, however, had a prognosis of more than 60% to live two months, and more than 40% to live six months, on the day before death. So, any criterion requiring less than a 50-50 chance to live two months would exclude virtually all of those who die with congestive heart failure. J. Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duquesne L. Rev. 311-336 (1996).

nal illness" mainly deals with cancer, neurological degenerative disease, and AIDS patients, all persons who have no available treatment, are losing weight and function, and who are psychologically "ready" to die. Most persons dying of chronic organ system failure will be excluded with a restrictive threshold and many persons with substantial opportunities for treatment and prolonged survival will be encompassed within an inclusive threshold.⁵¹

Fourth, the prognosis for survival can depend upon patient and physician choice and availability of treatment. A person with diabetes could stop insulin, a person with a feeding tube could stop its use, or a person with heart disease could be refused for transplant. If thereby such a person becomes "terminally ill," then the category is disquietingly dependent upon volitional actions rather than patient status.

Thus, defining the category of terminal illness with a statistical threshold would be arbitrary and certain to overinclude and underinclude substantial populations.

3. Disease Threshold.

The third way to define "terminal illness" ties the classification to clinically significant and morally important events, such as the recurrence of cancer in a distant site or the onset of fecal incontinence in a demented person.

⁵¹ *Id.* Half of all persons who die of lung cancer today will have had a prognosis of better than 30% to live 2 months, just one week ago, so any more restrictive threshold will miss most persons dying of lung cancer. Conversely, such a threshold will include many persons with acute respiratory, cardiac, or liver failure, who usually are vigorously treated. In fact, they qualify for transplantation only when they become so severely ill. If the category were expanded to include everyone with up to a 50% chance to live six months, most nursing home residents would qualify. If the category were restricted to those with a 1% chance to live two months, not only would one exclude virtually all cancer patients but those in the category would be so sick that they would, on average, die within a day. See also J.M. Teno, et al., *Prognosis-Based Futility Guidelines: Does Anyone Win?*, 42 J. Am. Geriatrics Soc'y 1202-1207 (1994).

However, an individual's status is not well characterized by the extent of one serious disease. Rather, a person's future is shaped by a variety of illnesses; reserve capacity of various organs; social situation; personal preferences; and treatment availability, use, and response. Thus, many of the patients included will actually have long expected life spans. This method is also afflicted with problems described above with regard to a statistical criterion.

Thus, no approach to defining terminal illness offers a simple and feasible method for determining who should have access to PAS. The problems appear to be intractable and no experience yet shows that they can be overcome.

Finally, even if terminal illness could be satisfactorily defined, it would not last long as a restriction on PAS. The courts below held, for example, that there are no differences between PAS and FLST. If that were true, requiring terminal illness would eventually be dropped, since there is no such requirement for FLST.

B. Competence.

Another criterion, upon which the right to PAS recognized by the courts below is contingent, is competency at the time the request for PAS is made and implemented. This criterion is also problematic. Classifying competence is difficult and sometimes impossible. In addition, the requirement raises troubling questions about PAS, since it may induce patients to choose suicide preemptively, in order to preclude losing the option through a subsequent deterioration in their mental faculties. Furthermore, the competence requirement interacts with the requirement for being terminally ill, since patients tend to lose competence as illness becomes more severe.

Although a variety of legal and medical decisions are predicated on a finding of competency, there is no uniform standard or set of procedures for making this deter-

mination.⁵² In practice, such judgments typically are made by health care professionals, in consultation with family members, and may be influenced by many factors, including the purpose of the evaluation. No professional discussion yet addresses appropriate competence standards for PAS, what components of cognitive and emotional functioning should be measured, or how capable the person must be in each component (or all taken together) in order to qualify for PAS.

The seriously ill commonly have deficits in cognitive and emotional functioning which change over relatively short periods of time and correlate strongly with suicide inquiries. Many elderly patients and dying cancer patients experience delirium, a syndrome in which they are confused, unable to maintain attention, and unable to master new information.⁵³ Most episodes are not detected in usual care. Likewise, depression is common, serious, and often undetected and untreated.⁵⁴ Depression, delirium, and mood disorders strongly correlate with suicide. Indeed, most cancer patients now committing suicide have discernible psychiatric illness, and having such an illness corresponds strongly with risk of suicide.⁵⁵ Treatment of depression substantially alters an initial inclination to refuse life-sustaining treatment.⁵⁶ Excluding these patients from access to PAS would be essential, but that turns

⁵² Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities To Consent To Treatment*, 319 New Eng. J. Med. 1635-1638 (1988).

⁵³ J. Francis, et al., *A Prospective Study Of Delirium In Hospitalized Elderly*, 263 JAMA 1097-1101 (1990); William Brietbart, et al., *Neuropsychiatric Syndromes and Psychological Symptoms in Patients with Advanced Cancer*, 10 J. Pain Symptom Mgmt. 131-141 (1995).

⁵⁴ Brietbart et al., *supra* note 53.

⁵⁵ Breitbart, *supra* note 13.

⁵⁶ Linda Ganzini, *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 Am. J. Psychiatry 1631-1636 (1994).

out to be quite difficult. Most depression, just like most delirium, is not recognized or treated in current practice.⁵⁷ The risks of involving persons with diminished capacity in PAS are substantial. Furthermore, a narrow definition of terminal illness will yield high rates of incompetence while a broader definition will yield high rates of long survival.

Moreover, as suggested above, a special problem with a lengthy dying process is fear of the indignity associated with incompetence.⁵⁸ If the right to PAS extends only to those with contemporaneous competence, then patients with conditions likely to lead to incompetence may find it appealing to undertake preemptive suicide. This is a special risk in early dementia, when patients retain ability to understand but have failing memory. The rate of progression to cognitive disability is unpredictable. Thus dementia patients hoping to avoid the worst-case scenario may be sacrificing many comfortable and relatively capable years when they seek PAS preemptively.

C. Undue Influence—Coercion.

1. The Context of Care.

Proponents of a constitutional right to PAS expect the practice to be limited to persons who are acting voluntarily, without undue influence or coercion. The image is that of an independent, capable person thoughtfully evaluating his or her options, unaffected by biased third parties or other circumstances. This is so far from the experience of dying as to be fanciful. Dying persons are often very weak, prone to strong emotions, and vulnerable to the suggestions, expectations, and guidance of others. In this context, pressure or encouragement from family, friends, and caregivers may cloud or overwhelm the patient's in-

⁵⁷ S.R. Rapp, et al., *Detecting Depression In Elderly Medical Inpatients*, 56 J. Consult. Clin. Psychol. 509-513 (1988).

⁵⁸ *Supra* note 8; *supra* note 13; see also P.J. Van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669-674 (1991).

dependent judgment and thus amount to inappropriate coercion.⁶⁰

The health care available to the terminally ill may be the most important factor influencing the care provided and may result in requests for PAS that could be avoided if appropriate care were available. Large variations in whether people die at home or in a hospital in various regions of the country are strongly related to hospital bed supply and regional hospice investment, and not to preferences, wealth, family presence, or other patient characteristics.⁶⁰

2. Financial Considerations.

Patients nearing death are generally quite disabled and their care is costly. While hospital and physician costs decline past the age of 70, long-term care costs rise, and these are mostly borne privately.⁶¹

The plaintiff-patients in the cases below do not appear to have been burdened with economic difficulties. Yet, economic influences are among the most important in defining a population eligible for PAS. One-quarter of those over 65 are below 150% of the Federal poverty level, and institutional long-term care has become largely a poverty program under Medicaid.⁶² As pressures increase to curtail health care expenses, hospital admissions are limited and hospitalizations are shortened. Decreasing availability and increasing expense in health care and the

⁶⁰ H.M. Chocinov, et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185-1190 (1995).

⁶⁰ R. Pritchard, et al., *Regional Variation in the Place of Death*, 9 J. Gen Internal Med. 146a (1994); see also The Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Dartmouth Atlas of Health Care* (AHA Publishing 1996).

⁶¹ A Scitovsky, "The High Cost of Dying Revisited," 72 Milbank Mem. Fund. Q. Health Soc. 561-591 (1994).

⁶² *Id.*; see also Marilyn Moon, *Medicare Now and in the Future* (1996).

uncertain impact of managed care may intensify pressure to choose PAS.

Should financial pressures be considered undue influence or not? This is the special dilemma of those who serve the frail, disabled, and poor. The AGS's concern is that PAS may become inherently coercive in a society in which supportive services and medical care are often unavailable. It would be ironic, indeed, to have a constitutional right to PAS when there is no guarantee of access to health care.

D. Suffering.

The courts below also appear to assume that the right to PAS may be reliably limited to persons who are suffering or in pain. Medical practice has no consensus on how to define or measure such a state. Most patients can be physically comfortable without sedation, and sedation can always eliminate symptoms in persons near death. This course is available at present, without any change in the law, and thus precludes a requirement that the patient must have symptoms that cannot be relieved. While some may view such treatment as undesirable, it is difficult to see why death through PAS should be considered a distinctly better (and constitutionally dictated) policy option.

E. Physician Involvement.

There is little reason to believe that physicians now have expertise in modes of killing, yet all proposals for PAS mandate physician participation. Although the counseling skills and prescription-writing privileges of physicians might at first blush suggest that their involvement in PAS is appropriate, this Court should recognize the practical difficulties this requirement imposes upon medical caregivers. There is no drug approved as safe and effective and therefore no drug legally available for PAS,⁶³ no in-

⁶³ In a recent survey of Oregon physicians who would be eligible to prescribe under the 'Death with Dignity Act,' 50% of respondents

struction is given in medical texts,⁶⁴ and practice standards show pervasive inattention to counseling and symptom management for those near death. Physicians are usually required to inform patients of alternatives which might be advantageous. No proposal has exempted PAS, but the implications of having to broach this subject with seriously ill persons have not been considered in the discussions to date. The potential for engendering distrust and diminishing effectiveness in physician-patient encounters may justify not engaging physicians in this work. Without experience, recognizing a right to commit suicide through the assistance of physicians is clearly premature.

F. The Scope of Assistance.

The constitutional right to PAS articulated by the courts below limits the physician's aid to prescribing medications in lethal doses. Clinical experience suggests that this limit is untenable and will inevitably lead to demands for more active physician involvement in bringing about the patient's death.

If a physician were to prescribe medication in a dose which should be sufficient to cause death, the rulings below require that the patient seeking PAS actually ingest the drugs and do not provide for any further assistance by the physician. Very likely, patients will sometimes take too little of the drug, will be more resistant than expected, or might vomit and lose much of what was ingested. Determining the appropriate response to a partial overdose in the context of legal, assisted suicide would pose difficult problems for physicians, family members, or friends, since survival with brain damage and incompetence could result.

Such difficulties seem likely to lead to pressure to allow intravenous administration of lethal drugs, both because

said they did not know what to prescribe for PAS. M.A. Lee, et al., *Legalizing Assisted Suicide - Views of Physicians in Oregon*, 334 New Eng. J. Med. 310-315 (1996).

⁶⁴ A. Carron, et al., *What is Taught About Care for the Dying in Three General Medicine Texts?*, 44 J. Am. Geriatrics Soc'y, 533 (1996).

they are more reliable and because they bring about death without apparent symptoms, such as prolonged respiratory distress, that might be difficult for family members or attendants to witness. Limiting the scope of physician assistance to the prescription of lethal drugs is thus unlikely to be sustainable. The experiences of physician assisted death in The Netherlands suggest that a progression from patient self-administration of lethal medication to physician assistance with intravenous routes is a likely consequence of allowing PAS.⁶⁵

In summary, the criteria delimiting the boundaries of the constitutional right to PAS found by the courts below are inherently unstable, difficult or impossible to define, and probably incapable of application at the present time. Without the benefit of further experience, there simply is no way of knowing whether this society could accommodate the exercise of a constitutional right dependent on these eligibility criteria.

IV. THE COURT SHOULD VACATE THE ORDERS OF THE LOWER COURTS.

This Court should reverse the opinions of the lower courts, and decline to recognize a constitutional right to PAS for a limited class of persons at the end of life. This is clearly an issue that is not ripe for consideration by this Court now. We explicitly adopt the legal argument for this position as presented by the Project on Death in America in an *amicus* brief filed in these cases.⁶⁶

As explained above, no jurisdiction in the United States has yet had any experience with the practice that, it is contended, should be recognized as a fundamental right. The AGS has been opposed to legalizing PAS or physician involvement in euthanasia, primarily on the grounds that

⁶⁵ P.J. Van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669 (1991).

⁶⁶ See also Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 Duquesne L. Rev. 159-181 (1996).

our frail elderly patients are especially vulnerable to social coercion and that the well-being of those who are old and sick is not being carefully considered in the legislative and judicial discussion of this issue.

This is a very dynamic time with regard to care at the end of life. Only in the last few decades has living past the eighth decade become commonplace, and only recently has dying become a slow process in the setting of progressive chronic disease. New findings about what can be done with regard to relieving symptoms and supporting dying persons and their families are being reported regularly. States continue to debate both their support of the poor and their willingness to allow PAS. This is a time to enhance our understanding of how to care for dying patients, not a time to foreclose further learning by precluding innovation and evaluation.

Instead, we believe that the issue should be left to institutions more able to fashion flexible resolutions, with the benefit of further study and debate, such as state legislatures, the health care professions, and community organizations.

In this connection, we note that, should the Court agree with the Petitioners' arguments that the New York and Washington statutes do not violate the 14th Amendment, then the 10th Amendment could provide an additional constitutional framework for reversal.⁶⁷ Since the Constitution neither delegates to the federal government the power to regulate PAS, nor prohibits its regulation by "the States, [such power is] reserved to the States respectively, or to the people."⁶⁸

⁶⁷ See *New York v. United States*, 505 U.S. 144, 157 (1992) ("The question is not what power the Federal Government ought to have but what powers in fact have been given by the [States and] the people." (quoting *United States v. Butler*, 297 U.S. 1, 63 (1936))); see also *Mugler v. Kansas*, 123 U.S. 623, 664 (1887).

⁶⁸ U.S. Const. amend. X; see also *U.S. Term Limits v. Thornton*, 115 S. Ct. 1842, 1876 (1995) (Thomas, J., dissenting); *Garcia v.*

CONCLUSION

For the foregoing reasons, the judgments of the United States Courts of Appeals for the Second and Ninth Circuits should be reversed.

Respectfully submitted,

Of Counsel:

JOSEPH E. SCHMITZ
MAKAN DELRAHIM
PATTON & BOGGS, L.L.P.
2550 M Street, N.W.
Washington, D.C. 20037
(202) 457-6000

JOHN H. PICKERING *
ALI M. STOEPPELWERTH
WILMER, CUTLER & PICKERING
2445 M Street, N.W.
Washington, D.C. 20037
(202) 663-6200
* Counsel of Record
Counsel for Amicus Curiae

San Antonio Metro. Transit Auth., 469 U.S. 528, 546 (1985) ("The essence of our federal system is that within the realm of authority left open to them under the Constitution, the States must be equally free to engage in any activity that their citizens choose for the common weal, no matter how unorthodox or unnecessary anyone else—including the judiciary—deems state involvement to be.")

APPENDIX

APPENDIX**POSITION STATEMENT****Physician-Assisted Suicide and
Voluntary Active Euthanasia***AGS Ethics Committee ****BACKGROUND**

The American Geriatrics Society has previously issued a statement on Voluntary Active Euthanasia (VAE). The public debate on this subject has broadened to include Physician-Assisted Suicide (PAS) and reflects the concern of many individuals about control over the terminal phase of their lives. The Society has affirmed that patients have the authority to choose among available plans of care, but their autonomy is limited when there are substantial detrimental effects on the lives of others or their choices conflict with legal or professional standards. (See AGS position statement, "Medical Treatment Decisions Concerning Elderly Persons"). Advocates of extending legal and professional standards to include VAE and PAS believe it is the patient's right to choose deliberately to end his or her life, under circumstances of intolerable suffering, when that individual reasonably and voluntarily prefers death to the life that confronts him or her.

DEFINITION OF TERMS*Physician-Assisted Suicide*

When a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the sole purpose of assisting the patient to end his or her own life.

* Prepared by Margaret Drickamer, MD; reviewed and approved by the AGS Ethics Committee and the AGS Board of Directors, November 1994. Copies of this position statement may be obtained from the American Geriatrics Society.

Voluntary Active Euthanasia

When, at the request of the patient, a physician administers a medication or treatment, the sole intent of which is to end the patient's life.

Withholding or Withdrawing Treatment

When a medical intervention is either not given or the on-going use of the intervention is discontinued, allowing natural progression of the underlying disease state.

POSITION

1. For patients whose quality of life has become so poor as to make continued existence less preferable than death, the professional standard of care should be that of aggressive palliation, not that of intentional termination of life. It is morally acceptable for a physician to administer a medication with the intent of treating a symptom, knowing that the medication may have the unintended effect of hastening the patient's death. This approach may include the withholding or withdrawing of any medical intervention as well as the specific palliation of symptoms, even if this advances the moment of death. The patient's request for death should trigger the physician's thorough exploration and understanding of the patient's suffering and the reason the request is being made at that particular time.
2. Patients for whom these issues are relevant should be informed of two important facts: a. Profound pain can be relieved with analgesia or sedation, and b. Patients may choose to forgo any life-prolonging intervention, including artificial nutrition and hydration. Because these issues are often misunderstood, the physicians have the responsibility to inform their patients of these alternatives.
3. Laws prohibiting VAE and PAS should not be changed. In giving a patient the means to palliate his

or her symptoms, a physician may inadvertently provide the means for suicide (e.g., by prescribing necessary but potentially lethal medications). The law should differentiate between this situation and the intentional participation in the planning and execution of a suicide. Laws in many states remain very vague as to the extent to which the physician's participation is considered to be a breach of the law. The definition and legal status of PAS should be further clarified.

4. If PAS or VAE are legal in any jurisdiction, the AGS contends that the strongest protection for patients to make a choice free of coercion should be in place and that it should be illegal for professional caregivers to receive financial compensation for assisting in suicide or euthanasia.

RATIONALE FOR CONTINUED PROHIBITION

1. Historically, the fundamental goal of the doctor/patient relationship has been to comfort and to cure. To change the physician's role to one in which comfort includes the intentional termination of life is to alter this alliance and could undermine the trust between physician and patient.
2. Allowing for VAE and PAS (especially in view of the possibility for its use in Advance Directives where patients are no longer competent and their directives are subject to interpretation) opens the door for abuse of the frail, disabled, and economically disadvantaged of society.
3. It is the general consensus of the AGS that most individuals who consider PAS or VAE do so out of fear of the dying process. The vast majority of patients can be appropriately palliated (including the use of general sedation) and would choose this alternative if they had full confidence that the medical profession would do so. A thorough search for the

underlying reason for the request for death may uncover several areas amenable to potential interventions (e.g., undertreated physical symptoms, psychosocial or spiritual crisis, clinical depression, etc.).

4. Legalization of physician-assisted suicide might thwart society's resolve to expand services and resources aimed at caring for the terminally ill, dying patient.

RECOGNITION OF THE CONSEQUENCES OF CONTINUED PROHIBITION

1. By prohibiting physicians from participating in VAE or PAS, we are limiting the patient's autonomy to choose his or her mode of death. For a patient who has intractable suffering and a limited life span, who has turned down general sedation, and who wishes to avail him- or herself of the choice to plan or execute their own demise, we must withhold our professional assistance.
2. Knowing that a small number of patients will choose this alternative despite our professional nonparticipation, the AGS recognizes that its members may choose not to give professional support to the patient in this decision.

FUTURE DEBATE

The medical profession, as well as society as a whole, is continuing to address this issue. We encourage this continued debate as the physician's role in the care of the dying patient is further defined.

POSITION STATEMENT

The Care of Dying Patients: A Position Statement
from the American Geriatrics Society

*AGS Ethics Committee **

BACKGROUND

Dying is the final portion of the life cycle for all of us. Providing excellent, humane care to patients near the end of life, when curative means are either no longer possible or no longer desired by the patient, is an essential part of medicine. The American Geriatrics Society (AGS) recognizes that most people near the end of life desire and should be able to obtain attentive and effective care directed at relieving symptoms, maximizing comfort, and maintaining dignity and control. Providing excellent care to dying patients and their families is time consuming and requires expertise as well as compassion. Care of patients who are dying is more than just withholding burdensome treatments; it is the provision of a special form of medical care, one in which physicians can take pride and find fulfillment. Making such care regularly available will require improvements in systems for service delivery and in professional education.

DEFINITIONS

Patients Who are Dying

Within this document, people are considered to be dying when they have a progressive illness that is expected to end in death and for which there is no treatment that can substantially alter the outcome. Thus, people are dying when they have illnesses such as advanced dementia

* Prepared by Greg A. Sachs, MD; reviewed and approved by the AGS Ethics Committee and the AGS Board of Directors, May 1994. Copies of this position statement may be obtained from the American Geriatrics Society.

or severe congestive heart failure, in addition to illnesses more routinely recognized as terminal, such as advanced cancer. Care of dying patients also encompasses patients who have elected to forgo available treatments that might forestall death, such as dialysis for end stage renal disease.

Palliative Care

Within this document, palliative care, also referred to as comfort care, refers to care directed toward the quality of life of patients who are dying, including the relief of pain and other symptoms, attention to the psychological and spiritual needs of the patient, and providing support for the dying patient's family.

PATIENT CARE ISSUES

Position 1

The care of the dying patient, like all medical care, should be guided by the values and preferences of the individual patient.

Rationale

Optimal medical care of all patients, not just those who are dying, rests on frank and sensitive communication between patients and physicians. For dying patients, this ordinarily entails recognition and discussion of the facts surrounding prognosis and the likely course with a palliative plan of care. The conversations throughout must continue to elicit and respond to the patient's needs. When the patient loses decision-making capacity, care should be guided by these previous conversations as well as by written advance directives, if available.

Position 2

Palliative care of dying patients is an interdisciplinary undertaking that attends to the needs of both patient and family.

Rationale

In caring for dying patients, physicians must themselves develop a broad array of knowledge and skills and an attentiveness to comprehensive care. In addition, whether or not the patient is enrolled in a formal hospice program, physicians most often should function as members of a team. The team may include nurses, social workers, homemakers, home health aides, physical therapists, chaplains, volunteers, and the patient's family. Each team member contributes the special knowledge and the skills of his or her discipline to help meet the needs of dying patients. Together, team members provide care for the patient and assist the family in coping with the patient's dying and death. Family members (with "family" defined by the individual patient) usually play a critical role in both providing care for dying patients and in making decisions for dying patients who have lost decision-making capacity. Providing support for the patient's family, including a period after the patient dies, is an important aspect of the palliative care of dying patients.

Position 3.

Care for dying patients should focus on the relief of symptoms, not limited to pain, and should be addressed by both pharmacologic and nonpharmacologic means.

Rationale

Pain, anxiety, depression, dyspnea, constipation, and other symptoms can all be significantly ameliorated, if not eliminated, in the vast majority of dying patients, provided we employ fully our pharmacologic armamentarium and appropriate nonpharmacologic interventions. Symptoms should be treated vigorously, even if the unintended effect of these efforts is the hastening of death. Though not medical symptoms, dignity and control are central issues for many dying patients.

HEALTH CARE DELIVERY ISSUES

Position 4

Dying patients should be guaranteed access to comprehensive, interdisciplinary palliative care across the spectrum of care settings as part of any federal or state health care reform plan, without care being conditioned on the financial status of the patient.

Rationale

Palliative care is often provided most appropriately in the patient's own home, a setting where reimbursement is inadequate under many existing insurance plans. Dying patients should be able to receive palliative care in the home, the hospital, and the nursing home, depending on the needs and preferences of the patient, without a disruption in the continuity of the patient's care.

Position 5

Reimbursement policies should be modified to enhance the availability of palliative care.

Rationale

Patients and families are presently faced with major financial obstacles to choosing palliative care, while payment for continued highly technological, acute care (e.g., dialysis, ventilator care, etc.) is readily available. Physician reimbursement should also be modified to promote palliative care. Like other forms of primary care, palliative care is time consuming, does not involve highly reimbursed procedures, and requires substantial counseling of patients and families.

Position 6

Administrative and regulatory burdens that may serve as barriers to palliative care should be reduced.

Rationale

Currently, hospices providing care for dying patients face special administrative burdens in addition to the usual paperwork facing all health care institutions. Requirements regarding availability of family and a home for caregiving regularly prevent some patients from receiving palliative care through hospices. Uncertain or unavailable estimates of prognosis also may serve inappropriately to exclude patients in need of palliative care services. Regulations intended to promote adequate nutrition for nursing home residents and laws intended to prevent assisted suicide and euthanasia should be written or revised so that these issues are not confused with proper palliative care decisions and treatment.

EDUCATION ISSUES

Position 7

Physicians, as well as other health care professionals, at all levels of training should receive concrete, insightful, and culturally sensitive instruction in the optimal care of dying patients.

Rationale

Medical students and physicians in training in the United States today rarely receive specific and in-depth instruction on the care of dying patients. This instruction should address attitudes toward and reactions to death and care of the dying, symptom management (especially pain control and adequate use of narcotic analgesics), and communication skills. The importance of knowledge about the care of dying patients should be reinforced by evaluating it on board exams and other specialty certification exams.

Position 8

The public, including our patients and our colleagues, needs to be educated regarding the availability of pallia-

tive care as an important and desirable option for dying patients.

Rationale

It is the position of AGS that this kind of educational effort would benefit many by dispelling the notion that the only options available to dying patients are continued futile therapy in a medical setting or turning to assisted suicide or euthanasia (see related AGS position statement).

RESEARCH ISSUES

Position 9

Adequate funding for research on the optimal care of dying patients should be provided.

Rationale

Much of the information base needed to inform patients and physicians regarding optimal care of dying patients does not yet exist. Studies documenting the outcomes of various types of care plans, medications, and treatment settings, especially ones focused on the experience of the dying patient, should take place. Although traditional biomedical research on symptom relief is needed, much of what is already known about symptom relief is not implemented effectively because of professional ethical concerns about aggressive symptom management and institutional barriers to the provision of palliative care. Research on these matters, including educational approaches and interventions to promote palliative care, is needed.